MAXIMUS Federal Services

Case Number:	CM15-0208296		
Date Assigned:	10/27/2015	Date of Injury:	06/21/2011
Decision Date:	12/08/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/22/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 52-year-old female who sustained an industrial injury on 6-21-2011. A review of medical records indicates the injured worker is being treated for residual Achilles tendonitis with fibrosis, right chronic plantar fasciitis, status post bilateral open plantar fasciotomy and right gastrocnemius recession on 7-16-2014, bilateral gastro soleal equinus, and Tyloma left medial heel. Medical records dated 9-28-2015 noted pain to her right plantar heels well as right Achilles tendon pain and callus on her left heel. Pain scale was unavailable. Physical examination noted pain to palpation to the plantar central right heel. There was tenderness to palpation to the Achilles tendon. There was mild bilateral lower extremity edema with no erythema. Treatment has included surgery, steroid injections, and physical therapy (amount unknown). Utilization review form dated 10-6-2015 noncertified light weight scooter x 3 years and modified physical therapy 2 x a week over 12 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Light Weight Scooter for three years: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Power Mobility Devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: The claimant sustained a work injury to the left ankle in June 2011 when she tripped on steps. She underwent bilateral open plantar fasciotomies and a right gastrocnemius recession in July 2014. She continues to be treated for bilateral lower extremity pain. When seen in September 2015 she had multiple complaints. Her main concern was right plantar heel pain and she felt she had ongoing plantar fasciitis. She had tried physical therapy and injections. She was using athletics shoes and bilateral ankle foot orthosis. She was having right Achilles pain and had a left heel callus. Physical examination findings included right heel pain with palpation. There was right Achilles tendon scar tissue with tenderness. There was decreased right lower extremity strength and range of motion. There was mild bilateral lower extremity edema. A hyperkeratotic medial left heel lesion was debrided. Authorization for a lightweight scooter and for 24 sessions of physical therapy was requested. A power mobility device is not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. If there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the claimant is able to ambulate without reference to use of an assistive device. There are no reported upper extremity impairments that would prevent use of bilateral canes or forearm crutches if needed. The requested lightweight scooter is not medically necessary.

Physical Therapy two times a week for twelve weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury to the left ankle in June 2011 when she tripped on steps. She underwent bilateral open plantar fasciotomies and a right gastrocnemius recession in July 2014. She continues to be treated for bilateral lower extremity pain. When seen in September 2015 she had multiple complaints. Her main concern was right plantar heel pain and she felt she had ongoing plantar fasciitis. She had tried physical therapy and injections. She was using athletics shoes and bilateral ankle foot orthosis. She was having right Achilles pain and had a left heel callus. Physical examination findings included right heel pain with palpation. There was right Achilles tendon scar tissue with tenderness. There was decreased right lower extremity strength and range of motion. There was mild bilateral lower extremity edema. A hyperkeratotic medial left heel lesion was debrided. Authorization for a lightweight scooter and for 24 sessions of physical therapy was requested. The claimant is

being treated for chronic pain with no new injury or recent surgery and has already had physical therapy. Patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. A home exercise program could be performed as often as needed/appropriate rather than during scheduled therapy visits. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. The request is not medically necessary.